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SUBJECT: Darfur Health Assessment

Summary and Comment

¶1. Since the escalation of the conflict in Darfur in 2004, coordinated efforts within the humanitarian community have resulted in substantial improvement in the overall health and nutrition situation of conflict-affected communities. These advances are evidenced by a declining trend in crude mortality rates (CMR) and rates of global acute malnutrition (GAM) to levels below emergency thresholds. The North, South, and West Darfur State Ministries of Health (SMoH) are collaborating with U.N. and international non-government organization (NGO) partners to coordinate health and nutrition interventions, conduct cross-sectoral planning specifically linked with water and sanitation interventions, improve communicable disease and nutrition surveillance systems, control communicable diseases, provide community health and nutrition education, and increase access to primary health care (PHC), including reproductive health and nutrition services.

¶2. However, recent improvements in health and nutrition trends may soon be undermined by a variety of factors. Reduced donor funding has forced NGOs providing health and nutrition services to discontinue essential programming activities. The effectiveness and efficiency of humanitarian operations in Darfur are also constrained by limited access to insecure areas, frequent population movements, logistical shortfalls, high turnover of SMoH staff, and increasing government restrictions on international aid workers. Across Darfur, the health education sub-sector remains under-prioritized, and is often the first health intervention to be downsized as a result of reduced donor funding. Additionally, Darfur's resource-intensive curative methodology - which focuses on treatment rather than prevention - relies heavily on external donor funding, leaving both international organizations and the SMoH vulnerable to resource pipeline shortfalls. Furthermore, the standard of care offered under the current system may not be transferable to local health care providers following the resolution of conflict in Darfur.

¶3. Looking forward, USAID recommends that U.S. government (USG) agencies working in the health and nutrition sectors of Darfur seek to strengthen existing

primary health care and nutrition programs by directing future funds towards community-based activities in order to maintain their sustainability into the future. Funding should also be provided to maintain and expand health and nutrition early warning and surveillance systems, as well as strengthen the expanded program of immunizations (EPI) and national immunization days (NID) including measles. Finally, health education initiatives focused on preventing acute respiratory infection, diarrhea, and malaria have great potential to achieve widespread behavior change and improve health throughout the region if they are implemented and supervised correctly. End summary and comment.

Visits and Contacts

¶4. From April 23 to May 3, 2006, a USAID/OFDA Health Specialist traveled to North Darfur and South Darfur to assess the local health and nutrition situation and monitor OFDA-funded health programs in the region. In Khartoum, the health specialist met with a Khartoum-based USAID Medical Officer, U.N. agencies including the U.N. Children's Fund (UNICEF), U.N. World Health Organization (WHO), U.N. World Food Programme (WFP), and U.N. Population Fund (UNFPA), and OFDA implementing partners Action Contre la Faim (ACF), International Medical Corps (IMC), Save the Children-U.S. (SC/US), and World Vision International. In El Fasher, the specialist met with representatives from the North Darfur SMoH, Relief International (RI), GOAL, UNICEF, WHO, and UNFPA. While in North Darfur, the specialist accompanied GOAL health promotion, nutrition, and medical coordinators and a

doctor from the Kutum Ministry of Health (MoH) on a site visit to internally displaced person (IDP) camps in Kutum and Kassab. She also accompanied representatives from UNICEF, WHO, and the International Rescue Committee (IRC) on a site visit to Abu Shouk and Al Salaam IDP camps. In Nyala, the health specialist met with representatives from IMC, IRC, the American Refugee Committee (ARC), ACF, WHO, and UNICEF and conducted site visits to Kalma camp with ACF and IRC, to Al Salam camp with IMC, and to the ARC clinic in Nyala.

Health Assessment

¶5. Coordination: The health and nutrition sectors are coordinated by WHO and UNICEF, respectively. Both U.N. agencies are functioning appropriately as sector leads. However, coordination for the Health Education sub-sector is weak, with a failure to standardize methodologies leading to erratic use of information materials, variations in training methodology, and inadequate community follow-up for behavior change. Funding shortfalls which have forced WHO to cut human resources will significantly weaken regional coordination mechanisms and reduce WHO's ability to support Darfur's SMoH health surveillance and disease prevention activities. Funding shortfalls have also resulted in program cutbacks in critical resources such as community health workers, community based services, and knowledge surveys.

¶6. Health Surveillance, Trends, and Capacity: According to WHO, Darfur's CMR of 0.46/10,000/day and under 5 mortality rate (U5MR) of 0.79/10,000/day are both below the emergency threshold levels of 1/10,000/day and 2/10,000/day percent established by the Sphere Project. The WHO-supported Early Warning and Alert Response System (EWARS) for reportable diseases has improved local capacity to detect communicable disease incidents and

trends in many of Darfur's IDP camps. However, the reporting rate declined from 66 percent to 40 percent in 2005 as a result of insecurity, reduced humanitarian presence, and IDP population movements. Routine surveillance in areas not supported by international NGOs remains challenging due to continued insecurity and the logistics requirements needed to maintain ongoing data collection activities. Laboratory facilities lack necessary supplies and transportation challenges lead to difficulties in the proper collection and analysis of samples. Darfur's SMoH capacity for independent operations is constrained by a limited budget, and the general scarcity of human resources, equipment, and logistics capacity. Thus, local authorities rely heavily on international partners for health surveillance as well as disease prevention and treatment.

¶7. Morbidity and Mortality: According to WHO, the leading cause of mortality in Darfur across all age ranges is acute respiratory infection (ARI). Diarrhea (19 percent in North Darfur and 14 percent in South Darfur) and acute respiratory tract infections (ARI) (31 percent in North Darfur and 25 percent in South Darfur) account for the majority of the current morbidity rates for children less than 5 years of age. The current all age group malaria morbidity rate of 4 percent is expected to increase between June and September as a result of impending seasonal rains. Outbreaks of mumps and seasonal cases of meningitis in 2005 and 2006 were both controlled by rapid detection and response.

¶8. Preventive Medicine: Routine EPI coverage for diphtheria, pertussis, and tetanus in children less than one year of age among target populations has improved to 61 percent in the third quarter of 2005 (from 32 percent in the first quarter of 2005). Though vitamin A, iodine, and de-worming medications are not routinely administered under the EPI program, these items are distributed to children during irregularly scheduled National Immunization Days (NID). Measles and vitamin A coverage in UNICEF's target areas is 73 percent and 86 percent respectively. Darfur's EPI program is currently facing

coverage gaps due to general insecurity, lack of resources, and difficulty in maintaining cold-chain storage and transport of immunizations.

¶9. Environmental Health: In an effort to improve management of response to public health emergencies in Darfur, WHO has adopted a system to correlate environmental health indicators (water quality management, solid waste management, and vector control) with communicable disease control and prevention activities. This cross-sectoral link has allowed for rapid detection of disease, identification of the disease source, and enabled immediate intervention to stop further disease transmission at the onset of an outbreak. As a result, the Darfur region has experienced fewer disease outbreaks than the rest of Sudan. Resource and funding shortfalls necessitating reduced staffing for epidemiologists and environmental health threaten this critical linkage.

¶10. Primary Health Care Delivery: According to OCHA, access to PHC services in target communities is currently at 80 percent. However, health and nutrition services in IDP camps throughout Darfur function on a clinically based methodology that is unsustainable for both Darfur's State Ministries of Health and the international community. Diagnosis and treatment of diseases in camps is difficult to assess, but the USAID health specialist found extensive evidence of costly health care practices such as unwarranted drug prescriptions, over-administration of IV/IM drugs, extended length of in-patient care, and ineffective triage. Darfur's State

Ministries of Health have adopted the Integrated Management of Childhood Illnesses (IMCI) protocol. However, the USAID health specialist was unable to find these guidelines at any of the clinics she visited during her time in Darfur. NGOs provide most out-patient referrals while WHO funds most hospital and medical logistics activities. NGOs managing critical drug supplies reported infrequent shortages of essential medicines. IDPs are currently receiving health care free of charge, but the international community is evaluating beneficiary cost-sharing mechanisms to create a more sustainable system which can eventually be transferred to Darfur's State Ministries of Health.

¶11. Reproductive Health: Reproductive health care services, including antenatal, delivery, and post-natal care, are available at hospitals and NGO-supported health facilities in Darfur's major population centers. The region's maternal mortality ratio is currently estimated at 630 maternal deaths/100,000 live births. (Note: This estimate is based on incomplete data collected from hospitals and NGO clinics. Eighty percent of women in Darfur continue to deliver at home.) Safe motherhood services are available to 60 percent of women of childbearing age in UNFPA-targeted communities.

¶12. Malaria: The regional annual malaria prevalence rate peaks shortly after the rainy season. The control strategy for malaria in Darfur consists of clinical treatment with appropriate antibiotics (combined therapy), distribution of long-lasting insecticide treated bed nets, and the use of environmental control measures such as risk mapping and insecticides in IDP camps during the peak malaria season. Bed nets are currently available to only 41.6 percent of targeted households, and their appropriate use in the home has not been documented at the community level.

¶13. HIV/AIDS and SGBV: The prevalence of HIV/AIDS in Darfur is currently estimated at 2.7 percent. Though current testing rates are very low (only 16 people were tested in El Fasher in the last 2 years), OFDA implementing partners are beginning to increase HIV/AIDS education and prevention activities. Advocacy by the international community has improved case management and treatment guidelines for victims of sexual and gender based violence (SGBV). State Ministries of Health are currently reviewing SGBV management Protocols drafted by the MOH and the international community. UNFPA provides rape kits to NGOs for medical management. However, there

is currently no universally recognized SGBV surveillance mechanism for Darfur and NGOs have encountered difficulty in accessing post exposure prophylaxis (PEP).

Nutrition Assessment

¶14. Trends: According to the December 2005 Darfur Emergency Food Security and Nutrition Assessment published by WFP, UNICEF, and the U.N. Food and Agriculture Organization (FAO) in cooperation with Sudan's Government of National Unity (GNU), the nutrition situation in Darfur had improved and stabilized over the course of 2005. The prevalence rate of GAM in children 6-59 months of age has decreased from 21.8 percent in 2004 to 11.9 percent as of September 2005 and severe acute malnutrition (SAM) has decreased from 3.9 percent in 2004 to 1.4 as of September 2005. The report attributed improvements in nutrition indicators to improved food security, lack of disease outbreaks, and the establishment of a functioning nutritional surveillance system.

¶15. Surveillance: UNICEF collects nutritional information by conducting standard 30 x 30 surveys and coordinating routine nutrition surveillance at 12 urban feeding centers or rural sentinel sites in each of Darfur's three states. Recent NGO assessment surveys indicate that pockets of malnutrition persist in North Darfur. Additionally, the recent improvement in nutrition trends in Darfur is now threatened by a 50 percent reduction in food rations which coincides with the beginning of the regional hunger season. Micronutrient deficiencies including vitamin A, iron, and iodine are prevalent in children and women of reproductive age. Funding shortfalls resulting in reduced humanitarian presence will likely result in significant information gaps and undetected pockets of malnutrition throughout the area over the coming hunger season.

¶16. Feeding Programs: Admission rates to selective feeding programs have declined to less than half the number of admissions recorded in May 2005. Community therapeutic care (CTC) is being implemented in 80 percent of selective feeding programs, but to varying degrees by OFDA's various implementing partners. CTC protocols are not standardized, training is costly and therefore inaccessible, and the State Ministries of Health administer traditional more costly TFCs (note: USAID/OFDA and Global Health are planning to support CTC training in several regions in Africa including Sudan). Cure rates, mortality rates, and default rates for therapeutic feeding centers (TFCs) are consistent with Sphere standards. However, the supplementary feeding center (SFC) default rate of 39 percent is more than twice the international standard of 15 percent established under Sphere standards. The high SFC default rate may be linked to a general dissatisfaction with the corn soy blend (CSB) distributed in many feeding programs, maternal time constraints, or population movements linked to a variety of local factors. Exclusive breastfeeding for children less than 6 months old is above 65 percent. Health and nutrition education is provided at community clinics but requires routine follow-up.

Recent Health and Nutrition Gains Threatened by Funding Cuts

¶17. USAID should strengthen existing health programs in Darfur prior to expanding health services into rural communities. Currently, NGOs and Darfur's State Ministries of Health do not have adequate financial and technical capacity and are struggling to ensure the continued health of the people of Darfur.

¶18. USAID Health Specialist recommends the following course of action to consolidate, stabilize, and advance health and nutrition in Darfur:

a) Coordination: Support WHO and UNICEF to staff and coordinate health sector humanitarian interventions in Darfur, including efforts to control communicable diseases and monitor environmental health, in order to avoid impending gaps due to funding shortfalls.

b) Surveillance: Support WHO to continue disease surveillance via EWARS and build the capacity of Darfur's State Ministries of Health to ultimately assume responsibility for managing this important system. Current methods of data collected through NGOs operating in IDP camps and host communities should be expanded to include non-camp populations as capacity allows. Expand Darfur's nutritional surveillance system - including surveys, feeding center data, and sentinel site

information - as capacity allows. These systems are critical for early detection and response to public health emergencies in order to avoid massive disease outbreaks and increases in malnutrition rates.

c) Primary Health Care: Support existing basic PHC services in IDP camps and affected host communities. Where possible, support a local PHC structure that serves both IDP sites and host communities to improve capacity of Darfur's local health systems. Strongly promote the implementation of cost-effective community-based methods such as clinical and community IMCI. Improve triage procedures and strengthen coordination between health NGOs to reduce patient load as well as support community based therapy when appropriate. Support routine EPI and NIDs including vitamin A, de-worming medicine, and iodine distributions. Continue funding commodities such as basic essential medicines, vaccines, medical supplies, and nutritional products containing micronutrients. Continue to build local SMoH capacity to manage health finances, medical training, and drug inventory and control systems.

d) Selective Feeding: Provide technical support to increase health sector and community capacity to implement Community Therapeutic Care (CTC) programs in an effort to decrease long, costly inpatient nutritional care (note: this will be funded by USAID). Investigate the high SFC default rate and apply lessons learned to improve program efficacy.

e) Health Promotion: Monitor community based health and nutrition interventions to closely measure behavioral change. Strengthen community health and hygiene promotion activities by supporting sub-sector coordination and funding collaborative joint knowledge, attitudes, and practices (KAP) surveys. Encourage NGO collaboration to use these KAP surveys to formulate community training guidelines, standard training protocols, and information, education and communication (IEC) materials. Support the development of a joint monitoring system to follow up on KAP surveys and measure behavioral change. The association between positive behavioral change and the corresponding decrease in disease rates cannot be overemphasized. Maintain and prioritize transferable health interventions - including malaria prevention, diarrhea prevention, health seeking behavior, home based care, safe feeding practices, growth monitoring, and breastfeeding. Avoid expansion of medical clinics into new communities and focus attention to build and sustain IDP knowledge of community health best practices.

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